INITIAL DATA FORM: KANSAS SCHOOL FOR THE DEAF

450 E. Park, Olathe, KS 66061; 913-210-8149
FAX 913-324-0601

Has your child attended KSD before? Yes ❑ No ❑ Dates:_____ **Number _____**

Date Received_____ Date Enrolled_____ Date Entered_____ Official Exit Date_____

IMPORTANT: This will become part of the permanent record of your child if he/she attends KSD. Please answer all questions carefully and accurately. **Write clearly** and return this form promptly.

A. Student Information:

Name: First **Middle** **Last** **Birthdate** **Sex**

Nickname **Age** **USD #** **Grade** **Social Security #** **Birth City** **Birth State**

Parental Status of biological parents: ❑ Married ❑ Divorced ❑ Separated ❑ Single

Student lives with: Mother / Step-Mother / Foster Mother Father / Step –Father / Foster Father Guardian
(Circle all that apply)

Education: Please list all schools (including pre-school) your child has attended (most recent first).

Dates Attended	School	Address

Can your child wash and dress him/herself? ❑ Yes ❑No **Is your child potty trained?** ❑ Yes ❑No

Parent Information: *If student lives with a guardian, please compete section E in addition to Parent Info.*

Mother's Full Name
Deaf or Hard of Hearing? Yes ❑ No ❑

Street

City

State **Zip Code** **County**

Daytime Phone ❑ Landline ❑Cell ❑ Videophone

Evening Phone ❑ Landline ❑Cell ❑ Videophone

Cell Provider_____

E-Mail

Father's Full Name
Deaf or Hard of Hearing? Yes ❑ No ❑

Street

City

State **Zip Code** **County**

Daytime Phone ❑ Landline ❑Cell ❑ Videophone

Evening Phone ❑ Landline ❑Cell ❑ Videophone

Cell Provider_____

E-Mail

INITIAL DATA FORM: KANSAS SCHOOL FOR THE DEAF

450 E. Park, Olathe, KS 66061; 913-210-8149
FAX 913-324-0601

Parent Work Information:

Mother's Occupation

Employer

Street

City **State** **Zip**

Work Phone ❑ Landline ❑Cell ❑ Videophone

E-Mail

Father's Occupation

Employer

Street

City **State** **Zip**

Work Phone ❑ Landline ❑Cell ❑ Videophone

E-Mail

B. Hearing Loss Was the child born deaf? ❑ Yes ❑ No

Number of children in family?_____ At what age did you first suspect the child was deaf?_____

What was the cause of the hearing loss?_____

Name of the other Deaf/Hard of Hearing children in the family?_____

Does your child have a cochlear implant? ❑ Yes ❑ No Is the CI in: ❑ Both Ears? ❑ Right Ear ❑ Left Ear

When did your child get the implant? RE_____ LE _____

Who does your child see for CI mapping? _____

Does your child have a hearing aid? ❑ Yes ❑ No ❑ Both ears ❑ Right only ❑ Left only

If yes, who made the aid recommendation? _____

When did your child begin using an aid? _____How old is the aid? _____

Does the child have sign language skills? ❑ Yes ❑ No
Does the child have speech which can be understood by members of the family? ❑ Yes ❑ No
Does the child have speech which can be understood by strangers? ❑ Yes ❑ No

***P*lease list all people, agencies, clinics, etc., you have consulted about your child's hearing loss (most recent first).**

Date	Name & Address	What were you told?

INITIAL DATA FORM: KANSAS SCHOOL FOR THE DEAF

450 E. Park, Olathe, KS 66061; 913-210-8149
FAX 913-324-0601

C. Vision Does your child wear glasses/contacts? ❑ Yes ❑ No Family history of vision concerns? ❑ Yes ❑ No

Has your child ever had eye surgery? ❑ Yes ❑ No

Has your child ever been seen by an ophthalmologist or optometrist? ❑ Yes ❑ No

Other vision information about your child_____

D. Additional Information: **What other information can you provide about your child which the dorm or classroom teachers should know about your child's personal habits, i.e. bed-wetting, allergies, eating habits, etc.?**

E. Guardian Information: Is there legal documentation to support this guardianship? ❑ Yes ❑ No

Guardian's Full Name
Deaf or Hard of Hearing? Yes ❑ No ❑

Street

City

State **Zip Code** **County**

Daytime Phone ❑ Landline ❑Cell ❑ Videophone

Evening Phone ❑ Landline ❑Cell ❑ Videophone

Cell Provider_____

E-Mail

Guardian's Occupation

Employer

Street

City **State** **Zip**

Work Phone ❑ Landline ❑Cell ❑ Videophone

E-Mail

Case Manager Name & Contact Info

Date_____ Signature of Person Completing the Form_____

The Kansas School for the Deaf is committed to a policy of non-discrimination on the basis of race, sex, national origin, handicap or other non-merit reasons, in admissions, education programs or activities, and employment, all as required by applicable laws and regulations. Inquiries may be addressed to: Human Resources Director, Kansas School for the Deaf, 450 East Park, Olathe, KS 66061.

INITIAL DATA FORM: KANSAS SCHOOL FOR THE DEAF

450 E. Park, Olathe, KS 66061; 913-210-8149
FAX 913-324-0601

Authorization for the Release of Information

Student _____ **Date of Birth** _____

I hereby authorize: _____
_____
_____

To release the following information from any records maintained on my child:

__√__ All educational records, including those listed below

__√__ Audiological records

__√__ School Transcripts

__√__ Current IEP/Three Year Evaluation/Re-evaluation

__√__ Testing/evaluation/consent for placement in Special Education Programs

__√__ Guidance and Counseling records

__√__ Health records including immunization

__√__ Notice and consent for related services (speech therapy, OT, PT, etc.)

__√__ Vision Records

__√__ Other: (specify) _____

To be sent to:

Kansas School for the Deaf
Attention: Admissions
450 E. Park
Olathe, KS 66061
(913) 210-8149 / (913) 324-0601 fax
ksdoutreach@kssdb.org

I understand that I have the right to revoke this authorization at any time, except when actions have already been taken on the basis of this authorization. To revoke this authorization, I must provide written notice to the Kansas School for the Deaf by registered mail; return receipt requested.

Signature Date

Relationship to Student